REPORT
TO

THE HOUSE OF REPRESENTATIVES APPROPRIATIONS SUBCOMMITTEE ON HEALTH AND HUMAN SERVICES

SENATE APPROPRIATIONS COMMITTEE ON HEALTH AND HUMAN SERVICES

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILTIES, AND SUBSTANCE ABUSE SERVICES

AND

FISCAL RESEARCH DIVISION

REPORT ON

THE COMPREHENSIVE TREATMENT SERVICES PROGRAM (CTSP)

Session Law 2005-276
House Bill 622, Section 10.25

June 2006

NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES

EXECUTIVE SUMMARY

The General Assembly of North Carolina, in its 2001 Session, passed legislation to establish the Comprehensive Treatment Services Program (CTSP) for children (children/adolescents) at risk for institutionalization or other out-of-home placements. The Department of Health and Human Services (DHHS) was charged with the implementation of the Program in collaboration with the Division of Social Services (DSS), Department of Juvenile Justice and Delinquency Prevention (DJJDP), the Department of Public Instruction (DPI), the Administrative Office of the Courts (AOC) and other relevant State agencies to provide appropriate and medically necessary residential and non-residential treatment alternatives for the target population.

The infrastructure for Program implementation is in place and progress continues with expansion and quality improvement.

- The mechanism for funding community-based alternatives and eligibility criteria was expanded in 2004 legislation.
- Collaboratives formed at the State and Local community levels continue to build capacity through policy and guideline development.
- Local Management Entities (LMEs) continue to promote Consumer Family Advisory Councils (CFACs) and better support consumers and families in full participation and leadership.
- Families are represented in the State Collaborative and Local Community Collaboratives, which continue to formalize their structures.
- An integrated Memorandum of Agreement (MOA) exists between all relevant agencies at the State and local levels.
- The array of medically necessary non-residential and residential services has expanded through the development of new service definitions, approved in December 2005.
- Expansion continues with evidenced based, best and emerging best practice community based services with new definitions to be implemented March 20, 2006.
- The Program served 13,201 children/adolescents in state fiscal year (SFY) 2005.

INTRODUCTION AND HISTORICAL CONTEXT

It has long been recognized in the public service field that children/adolescents with complex mental health challenges can be kept out of institutional facilities through a coordinated system of services. As early as 1969, the Joint Commission on Mental Health of Children called for a broad array of services for the prevention and treatment of mental illness after a five-year study that started in 1964. The President's Commission on Mental Health urged a coordination of services in 1978. But not until the Willie M. Program (Soler and Warboys, 1990**)** was the concept "system of services" translated into practice on a massive scale. The Willie M. lawsuit guaranteed that each child/adolescent in the class had the right to individualized treatment based on needs, rather than available services, and to have these services provided in the least restrictive setting possible. The Willie M. program ended in 1998, when the lawsuit was dismissed and the State was found to be in compliance with the stipulations of the settlement (North Carolina Department of Health and Human Services and North Carolina Department of Public Instruction, 1999).

The termination of the Willie M. lawsuit in 1998 provided the opportunity to extend the delivery of a continuum of services to all children/adolescents with serious mental, emotional, and behavioral difficulties in all counties throughout the State. In its 2001 session, the General Assembly of North Carolina passed legislation to establish the Comprehensive Treatment Services Program (CTSP) for children/adolescents at risk for institutionalization or other out-of-home placements, marking the beginning of a statewide implementation of System of Care (SOC).

The State Collaborative for Children/Adolescents and Families was formed in 2001 to promote a coalition among agencies cited by the General Assembly in the legislation that established the Program. The Child Mental Health portion of the State plan is explicit in its support of SOC. The goal under the plan is to provide a "system of quality care, which includes accessible, culturally sensitive, individualized mental health treatment, intervention and prevention services delivered in the home and community in the least restrictive and most consistent manner possible." The emphasis on a SOC has been the catalyst for developing an inter-divisional and inter-departmental approach to serving children in communities, shaped significantly by the families served.

This report summarizes the progress achieved in implementation of the CTSP pursuant to Section 10.25 (a) & (m) of Session Law 2005-276, House Bill 397.

PROGRESS IN MEETING PROGRAM INDICATORS

SECTION 10.25. (a)

The Department of Health and Human Services shall continue the Comprehensive Treatment Services Program for children at risk for institutionalization or other out-of-home placement. The Program shall be implemented by the Department in consultation with the Department of Juvenile Justice and Delinquency Prevention, the Department of Public Instruction, and other appropriate State agencies. The purpose of the Program is to provide appropriate and medically necessary residential and nonresidential treatment alternatives for children/adolescents at risk of institutionalization or other out-of-home placement. Program funds shall be targeted for non-Medicaid eligible children. Program funds may also be used to expand a SOC approach for services to children/adolescents and their families statewide. The Program shall include the following:

(1) *Behavioral Health Screenings for all children/adolescents at risk of institutionalization or other out-of-home placement.*

- Behavioral health screenings are performed for all children/adolescents in the target population through funding allocations to the area authorities and county programs and directed at community provider agencies serving children/adolescents with severe emotional disorders.

- In 2005, an initiative of the Division of Social Services (DSS)-Division of Mental Health/Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) with a cross-section of other community agencies, community providers and academic researchers was formed to explore and develop common rules, definitions, protocols and guidelines based on evidenced-based, best and emerging best practices. A focus of the initiative was to promote the continuity of care, services and supports to children/adolescents needing foster care or in the foster care system. As a part of this group, a needs assessment sub-committee is working towards streamlining and aligning screening, assessment instruments and protocols across child/adolescent serving agencies.

- Eligibility determination for CTSP services is a joint process with the referring community agency, the

parent/caregiver, and the LME completing the assessment process as a team.

- Health Check, which is a component of Early, Periodic, Screening, Diagnosis and Treatment (EPSDT), in a joint collaborative agreement with the Division of Medical Assistance (DMA) and Department of Public Health (DPH), is to promote and provide a statewide comprehensive system for early and periodic screening of children/adolescents from birth to 21 years old who are Medicaid eligible.

(2) *Appropriate and medically necessary residential and non-residential services for deaf children* (who are deaf, hard of hearing (HOH), deaf-blind).

- The State has eligibility protocols to highlight specification for children/adolescents who are deaf, HOH or deaf-blind for specialized mental health, developmental disabilities and substance abuse services.
- A comprehensive service array for children/adolescents within this target population has been developed and implemented statewide. While regional clinicians provide the majority of direct services, the State assists local programs with making services language accessible, through interpreters as necessary.
- Specialized staff fluent in American Sign Language (ASL) works closely with public school systems, the two state schools for the deaf, advocacy groups, community collaboratives, Area Authorities and County Programs, consumer and provider organizations, and family members to ensure that SOC principles are utilized and specialized services are coordinated.
- In addition, in each of the last two fiscal years, additional interpreters have been funded through CTSP to the area authorities and county programs for sign language interpretation.

(3) *Appropriate and medically necessary residential and non residential treatment service, including placements for sexually aggressive youth* (Children/adolescents with challenging sexual behaviors).

- Children/adolescents with challenging sexual behaviors continue to be identified and included as a part of the target population eligible for CTSP funding.

- Appropriate and medically necessary residential and non-residential treatment services for children/adolescents are being addressed in the new service definitions, including Intensive-In-Home and Multi-Systemic Therapy (MST), effective in 2006. Changes in rules have coincided with service definition changes for implementation consistency across service levels.

- Division research is being conducted on evidenced based, best and emerging best practices for working with children/adolescents with challenging sexual behaviors within a SOC approach.

- The DMH/DD/SAS sponsors statewide training opportunities for agencies who serve children/adolescents with challenging sexual behaviors, through the Annual Statewide Community Case Management Conference. The 17th Annual Statewide Case Management Conference "Transforming to Community Support and Targeted Case Management: Making the Change!" was held November 8-10, 2004, Charlotte, NC. The 18th Annual Statewide Community Support/Targeted Case Management Conference was held November 8-10, 2005, in Charlotte, NC.

(4) *Appropriate and medically necessary residential and non-residential treatment services, including placements for youth needing substance abuse* (substance-related use) *treatment services and children with serious emotional disturbances* (SED).

- Legislation in SFY 2004 provided for policy and guidelines to be put in place for SFY 2005 to provide more flexibility in the use of funds. This provided additional services and supports to benefit children/adolescents with substance-related use disorders who are at risk of out-of-home placements.

- Residential and non-residential services and supports for children/adolescents with substance-related use disorders are being addressed through a revision of the rules and service definitions to better reflect evidenced based, best and emerging best practices through a SOC approach.

- A Child/Adolescent Substance Abuse Specialist participates in monthly meetings of the Child Mental Health workgroup and actively assists in incorporating substance use issues into policy and guideline planning.

- Substance Abuse Block Grant funds are dedicated to the development of community-based treatment options for children/adolescents with substance-related use issues.

- On July 20, 2005, an award from the Substance Abuse and Mental Health Services Administration was issued for The Adolescent Treatment Coordination Grant for the period of August 1, 2005 – July 31, 2008. The project will develop a sustainable infrastructure for substance-related use treatment coordination that will strengthen the capacity of the DMH/DD/SAS to serve adolescents in need of substance-related use disorders and their families. This project builds on an existing collaborative effort between parents and adolescents, DMH/DD/SAS, DJJDP and other child/adolescent serving public and private agencies as part of the operationalization of the CTSP and the Managing Access for Juvenile Offender Resources and Services (MAJORS) program.

(5) Multidisciplinary case management services, as needed.

- Child and Family Team (CFT) structures and the person-centered plan (PCP) address case management across all child/adolescent serving agencies. The intent is to provide continuity of care and assist in the coordination and monitoring of multiple services to ensure that desired outcomes are achieved.

- A new service definition array will be implemented SFY 2006, with definitions that serve to combine case management functions with other interventions increasing the availability and coverage of evidenced-based, best and emerging best practice services and supports.

(6) *A system of utilization review specific to the nature and design of the Program.*

- Local Community Collaboratives continue to be responsible for assessing and managing local resources, and overseeing expenditures of service funds.

- CFTs identify and assess the needs of each child/adolescent, in partnership with the family to ensure comprehensive care.

- Adherence to Level of Care (LOC) criteria is required for mental health services delivered through the CFTs. Value Options provides Utilization Review (UR) for Medicaid services and has incorporated the SOC model into their UR protocols. Further development of a system of UR is underway through the State Plan to provide the right intensity of service at the appropriate time.

(7) *Mechanisms to ensure that children are not placed in department of social services custody for the purpose of obtaining mental health residential treatment services.*

- The DSS-DMH/DD/SAS MOA developed in 2002-2003, makes clear that unnecessary placements with the DSS are not allowed.

- The State Collaborative has recommended that the Social Services Block Grant Plan include an allocation to serve as a flexible source of funds with specific requirements to divert unnecessary DSS custody.

- In keeping with the principles and values of SOC and the outcomes identified and implemented in the PCP, familial bonds are respected and protected. Families should not have to give up custody of their children in order to obtain appropriate services.

(8) *Mechanisms to maximize current State and local funds and to expand use of Medicaid funds to accomplish the intent of this Program.*

- In a memorandum from the DMH/DD/SAS on December 3, 2004, Area Authority/County Program directors were notified of additional CTSP Funding Guidelines for UCR and Non-UCR funds effective December 1, 2004. The changes allow for the expansion in 2005 of the use of CTSP funds for additional children/adolescents who are at-risk for out of home placement, and for additional services. The guidelines were to increase flexibility in the use of UCR and Non-UCR CTSP funding to support and sustain SOC as a best practice for children/adolescents with mental health and/or substance use disorders.

- The guidelines were also to support and encourage the use of funds for training and technical assistance to facilitate system change and establish evidenced based, best and emerging best practices in a comprehensive SOC.

- Research in evidenced based, best and emerging best practices indicates that in-home services such as Intensive-In-Home and MST promote family preservation and have positive outcomes for children with SED and their families. As a response to this, a Request for Applications (RFA) to Area Authorities and County Programs was issued by the Division in SFY 2005, for the distribution of $1.8 million in MH/DD/SAS Trust Funds. Funds were allocated as start-up funding to increase child/adolescent mental health community-based services capacity. Funding was specifically identified for the establishment of Intensive In-Home services, with respite and crisis components, or to enhance existing Intensive In-Home services in the communities.

- Services options were increased with State funds through the allocation of funds reserved for family participation, and other services that met the individualized needs of children/adolescents in the Program.

- Provisions were included for LMEs and community collaboratives to prioritize and meet service needs using Non-UCR funding for prevention and early intervention services and supports, as well as start up for building community capacity.

- For children/adolescents identified as CTSP eligible, the majority of funds expended for services - $257,000,000 were paid through Medicaid. The total expended through Integrated Payment and Reporting System (IPRS) for UCR earnings was approximately $30,000,000.

(9) *Other appropriate components to accomplish the Program's purpose.*

- New service definitions will go into effect in March 2006, with an emphasis on services and supports, and a case management model of delivery, within the context of each service definition.

- Definitions will include services and supports within models including MST and Intensive-In-Home Services, and Community Support which are evidenced based and best practice models utilizing a SOC approach.

(10) *The Secretary of the Department of Health and Human Services may enter into contracts with residential service providers.*

- Contracting with residential providers has been successfully managed at the LME level; however, if

necessary the Secretary of DHHS may enter into contracts with providers.

(11) *A system of identifying and tracking children/adolescents placed outside of the family unit in group homes, therapeutic foster care home settings, and other out-of-home placements.*

- IPRS started in SFY 2004 with every LME in SFY 2005 successfully billing IPRS, except for Smoky Mountain Center and Piedmont Behavioral Health Care who are engaged in pilot demonstration projects which include their CTSP funding.

- The State Collaborative formulated a Communication Protocol that is in place to delineate the procedures for local MH/DD/SAS, DSS, Local Education Authorities (LEAs) and juvenile justice agencies use if they are involved with a child/adolescent who is transferring from a local community to receive residential services in another community.

SECTION 10.25 (b)

In order to ensure that children/adolescents at risk for institutionalization or other out-of-home placement are appropriately served by the mental health, developmental disabilities, and substance abuse services system, the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services shall do the following with respect to services provided to these children:

(1) *Provide only those treatment services that are medically necessary.*

- Service definitions identify medically necessary Entrance Criteria, Continued Stay Criteria and Discharge Criteria, consistent with the Child Level of Care Criteria. Criteria provide guidance for the decision-making process in ensuring the needs of children/ adolescents are clearly identified, addressed and reassessed for services and supports on the continuum of treatment needs and outcomes.

- The DHHS is charged with the implementation of the Program in collaboration with the DSS, DJJDP, the DPI, and other relevant State agencies to provide appropriate and medically necessary residential and non-residential treatment alternatives for the target population.

(2) *Implement utilization review of services provided.*

- The DMH/DD/SAS is expanding the system of UR of all the services, including those specific to CTSP.

(3) *Adopt the following guiding principles for provision of services:*

(a) *Service delivery system must be outcome-oriented and evaluation-based.*

- A SOC approach incorporates and requires adherence to the principles referenced in the 2004-2005 legislation. CTSP continues to be implemented through a statewide SOC approach, i.e., outcome-oriented, evaluation-based.

- Outcomes data is being collected for children/adolescents through the North Carolina Treatment Outcomes and Program Performance System (NC-TOPPS).

(b) *Services should be delivered as close as possible to the child's home.*

- Principles and values of the SOC include continuity of care for all eligible children and is supported through case management and interagency planning and training with the family through the CFT.

(c) *Services selected should be those that are most efficient in terms of cost and effectiveness.*

- The integration of all involved parties in one comprehensive CFT reduces duplication of services and fragmentation of delivery. Services delivered are those agreed upon by the CFT and approved through UR.

- Evidence based, best and emerging best practices, including the SOC approach continue to be identified and developed for implementation through service definition and rule revision to ensure efficient and effective services and supports.

- In 2005, research and evaluation on evidenced based, best and emerging best practices for children/adolescents was initiated and continues to be promoted and conducted through the North Carolina Practice Improvement Collaborative (NCPIC).

(d) *Services should not be provided solely for the convenience of the provider or the client.*

- Services are those determined through the process of the PCP to identify and address positive life outcomes through addressing medically necessary needs of the child/adolescent. The CFT includes cross agency services and service providers so there is full community representation and collaboration consistent with a SOC approach.

(e) *Families and consumers* (children/adolescents) *are involved in decision making throughout treatment planning and delivery.*

- The MOAs outlining specific agency responsibilities in the planning and care for affected children/adolescents have been signed by agencies at the State and local levels.

- A core value of a SOC approach is the active involvement of families at all levels of service, program and system activities.

- A parent of a child/adolescent with SED co-chairs the State Collaborative and all Local Community Collaboratives require, support and actively encourage full participation of family members to represent the interests of local families.

- Recent allocation of CTSP funding includes a mandatory dedication of a percentage of funds to support the involvement of families in SOC. Family members actively participate in the State Collaborative and in Local Community Collaboratives.

- Families are key to meeting the challenge in building capacity throughout North Carolina's human services, educational and juvenile justice agencies and in the expansion of SOC.

- A high priority and key component of the Mental Health Planning Council is family involvement to ensure effective planning for services and supports for children/adolescents and their families.

- The DMH/DD/SAS continues to work closely with family members through the State Collaborative for Children's

Services in revising the Child Mental Health Plan addressing other child mental health initiatives.

- In addition to working through the State and Local Collaboratives, in SFY04-05, the DMH/DD/SAS worked closely with organizations and advocacy groups who have a primary interest in child mental health to increase family member involvement locally and on the state level. These groups include the Mental Health Planning Council, the National Alliance for the Mentally Ill, the Mental Health Association, Families CAN, the NC Family Support Network, the Child Advocacy Institute, and the Covenant for Children, Coalition 2000, North Carolina Families United and parent support groups in local communities.

- Collaboratives, the planning structures with representatives from all child-serving agencies and community stakeholders, are being supported and maintained at the State and local levels.

- CTSP legislation requires the Collaboratives to include family members and consumers who have children/adolescents currently in the system or who have been in the system.

- A Community Collaborative Survey, conducted in June 2005 assessed the effectiveness and involvement of families and consumers of the Local Collaboratives.

- The number of children/adolescents served by CTSP funds has increased. Approximately 13,201 children/adolescents were served in SFY 2005, a major increase compared to the 2,941 served in SFY 2001, with the initiation of the Program.

- **UCR and Non-UCR Expenditures for SFY 2004 and SFY 2005**

	SFY 2004	**SFY 2005 ***
UCR	$34,683,047	$25,089,268
Non-UCR	$908,198	$2,720,957

* Note that the numbers for 2005 do not include data for both Piedmont and Smoky Mountain as a result of their pilot demonstration projects.

(4) *Implement all of the following cost reduction strategies:*

(a) *Preauthorization of all services except emergency services.*

- CFTs, through the process of the PCP develop medically necessary supports and services for positive outcomes.

- Each service definition incorporates the Initial, Continuation and Discharge criteria which provide the protocol for guiding decision-making in providing the right intensity of service at the appropriate time.

(b) *Levels of care to assist in the development of treatment plans.*

- New initiatives will be effective in 2006, to ensure local management by the LMEs in providing UR for all state-funded services, including those funded by CTSP. Local Community Collaboratives manage utilization at the local aggregate level.

(c) *Clinically appropriate services.*

- The Initial and Continuing Authorization Criteria describe the clinical indicators that should exist to consider the authorization of a particular service and facilitate care management.

SECTION 10.25 (c)

The Department shall collaborate with other affected State agencies such as the Department of Juvenile Justice and Delinquency Prevention, Department of Public Instruction, the Administrative Office of the Courts, and with local department of social services, area mental health programs, and local education agencies to eliminate cost shifting and facilitate cost-sharing among these governmental agencies with respect to the treatment and placement services.

- The State Collaborative's list of accomplishments is extensive. This group has provided valuable input into the NC-TOPPS, and supported the pursuit of grant and foundation funds at the state, regional and local levels. The Collaborative is represented by DHHS, DJJDP, DPI and respective divisions & staff from these state agencies, NC Interagency Collaborating Council, advocates, families, providers, community collaborative partners, and the faith-based community.

- The primary focus of the CTSP legislative initiative is provision of services and system collaboration with a focus on children with

SED who are served by multiple agencies, and are in, or at risk for, out of home placement. Emphasis is placed on family involvement and agency collaboration at local, regional and state levels.

- Through the collaboration of state agencies, diversions have occurred from training schools, state psychiatric institutions and DSS custody.

- Initiatives like the Managing Access for Juvenile Offender Resources and Services (MAJORS) program provides evaluation, diversion, training and technical assistance to substance-related use and SED juvenile justice involved children/adolescents.

- State agencies continue to collaborate to eliminate cost-shifting and facilitate cost-sharing. Agencies including DPI provide much of the matching funds required of federal grants, particularly in the SOC Demonstration Projects.

- A cooperative agreement between DPI and the DHHS facilitates compliance with the regulations set forth under Part B (3-20) of the Individuals with Disabilities Education Act (IDEA as amended) as they pertain to children with disabilities served by both agencies. This agreement focuses on providing educational services for students with disabilities that are in DHHS residential facilities. The DHHS serves as a Local Education Agency (LEA) with education.

- The State Collaborative continues to meet monthly with the goal of improving outcomes for children/adolescents and families, especially but not limited to those with MH/DD/SA needs, through an SOC framework for community based services and supports.

SECTION 10.25. (d)

Department shall not allocate funds appropriated for Program services until a Memorandum of Agreement (MOA) *has been executed between the Department of Health and Human Services, the Department of Public Instruction, and other affected State agencies.*

- The State Collaborative has been successful in developing one integrated MOA between all relevant State agencies, including DHHS, DPI, AOC and DSS, Area Authorities and County Programs, and LEAs. The MOA delineates responsibilities of local child-serving agencies.

- The current MOA is in effect and a meeting of the relevant agencies was held to review commitments and make necessary adjustments that are reflective of changing mandates between and within the individual agencies.

SECTION 10.25. (e)

Notwithstanding any other provision of law to the contrary, services under the Comprehensive Treatment Services Program, are not an entitlement for non-Medicaid eligible children served by the Program.

- All training and correspondence relevant to this topic emphasizes that services are not an entitlement.

SECTION 10.25. (f)

Of the funds appropriated in this act for the Comprehensive Treatment Services Program, the Department of Health and Human Services shall establish a reserve of three percent (3%) to ensure availability of these funds to address specialized needs for children with unique or highly complex problems.

- The North Carolina DMH/DD/SAS issued the December 3, 2004 memorandum, "Expanded CTSP Funding Guidelines for Area Authority/County Programs for UCR and Non-UCR Funds".

- The Division approved Non-UCR CTSP funding reallocations for twenty area authorities and county programs. Area authorities and County Programs approved for Non-UCR expenditures were required to submit year-end activity reports by August 31, 2005. The Non-UCR funding requests that were approved in SFY 04-05 totaled $2,720,957.

SECTION 10.25 (g)

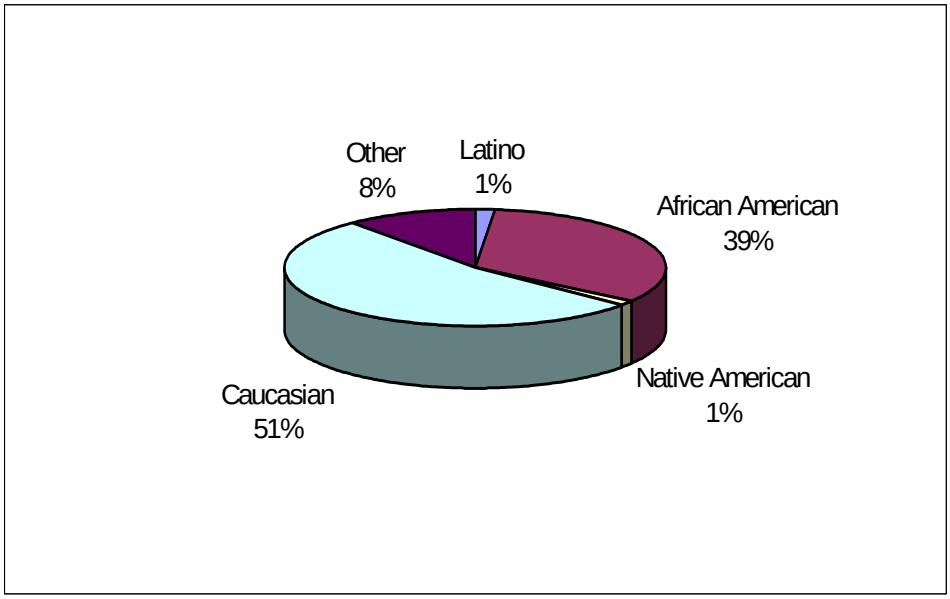
The Department of Health and Human Services, in conjunction with the Department of Juvenile Justice and Delinquency Prevention, Department of Public Instruction, and other relevant agencies, shall report on the following Program information:

(1) *Number and other demographic information of children served.*

- A total of 13,201 children/adolescents were served in SFY 2005.

- The number of referrals from various sources, particularly from schools and the public health system has increased resulting in the increased number of children/adolescents enrolled in the Program.

- Children/adolescents served by CTSP funding were predominantly Caucasian, the remaining include a diversity of subgroups; about 39% were African Americans; 1 percent (1.4%) were Native Americans (Chart). The "Other" category included those of Asian origin (.2%). The "Hispanic" category consisted of Latinos from a variety of ethnic backgrounds.



(N = 13,201)

(2) *Amount and source of funds expended to implement the Program.*

- About $257,000,000 was expended to serve children in the program with the bulk expended through Medicaid funding.

- The total expended through IPRS for UCR earnings was approximately $30,000,000 based on claims paid through January 2006.

(3) *Information regarding the number of children screened, specific placement of children, including the placement of children in programs or facilities outside the child's home county, and treatment needs of children served.*

- All children/adolescents referred for enrollment into the Program are screened to determine whether they meet eligibility criteria and are eventually entered into the IPRS data base. However, the total number who was screened by all of the child-serving agencies who did not meet the Program's eligibility criteria is unknown.

- Data Collected between July 1, 2005 and December 31, 2005, on 6,295 children/adolescents through the web-based NC-TOPPS showed most of the children/adolescents lived with their parents or guardians (76%); 17 percent were in group homes.

Living Situation

Parent or Guardian Home	76%
Residential Program	17%
Institution/facility	2%
Temporary Housing	4%
Other	4 %

- The number of children entering DSS custody for the first time increased slightly from 5,565 in SFY 2004, to 5,883 in SFY 2005. However, the percentage of children/adolescents ever placed in non-family settings declined from 22 percent in SFY 2004, to18 percent in SFY 2005.

(4) *Average length of stay in residential treatment, transition and return to home.*

Average Length of Stay in Residential Treatment SFY 2005		
Type of Service	**Number of children and adolescents served**	**Average Length of Stay (Days)**
Level II	2,557	170
Level III	4,428	163
Level IV	201	98
Psych. Residential Treatment (PRTF)	298	114
Inpatient hospital	1,428	19

- Each of these services has specific medical necessity requirements so that a child's needs are matched to the correct type of residential setting and goals are specified in the child's Person Centered Plan. When a child has achieved his/her goals related to the residential service that is being provided, the child may transition back to his/her family or to a less intensive level of residential care if that is needed. A utilization review process is in place to monitor progress toward goals and to determine whether the individual is in need of continuing to receive service at the current level of residential service or whether

services of less or greater intensity are indicated to meet the individual child's current needs.

(5) *The number of children diverted from institutions or other out of home placements such as training schools (*Youth Development Centers) *and State psychiatric hospitals and a description of the services provided.*

- Initiatives like the MAJORS program provide evaluation, training, technical assistance and diversion from court involvement to substance-related use juvenile justice involved children and adolescents.

- With the dismissal of the Willie M. lawsuit, and the integration of children/adolescents into a more comprehensive array of MH/DD/SAS, the LMEs no longer tracked diversions of children/adolescents who were part of the Willie M. class.

(6) *Recommendation on other areas of the Program that need to be improved.*

- Children/adolescents who are at risk for co-occurring service needs such as those experiencing fetal alcohol syndrome spectrum disorder, those who have been exposed to community or domestic violence and other trauma will need a different level of clinically trained professionals who can provide trauma specific focused treatment services. Recommendations to address these needs are contained in three different reports being drafted for release in SFY 2006; one, a legislative study regarding domestic violence and mental health/substance-related use treatment needs, the second, an Institute of Medicine report on prevention of child maltreatment and the third, a school mental health strategic plan through the State Collaborative.

- Building provider capacity as a whole continues to be a focus, especially in assessment, diagnosis, and implementation of evidenced based, best and emerging best practices.

- Cross- agency training and education needs to be a frequent, on-going activity to help staff from various child-serving agencies to better understand each agency's role in the service delivery process, the individual mandates, and potential barriers to service coordination for each agency.

- Private providers, children/adolescents and families continue to need incentives for training to ensure the System of Care approach and community collaboration is being successfully integrated into

all levels of supports and services, and how CTSP funding can be utilized in non-traditional as well as traditional ways.